

Bracing For Enforcers' Growing Focus On Behavioral Health

By **Jeffrey Fitzgerald** (May 22, 2026)

Rhetoric surrounding the federal government's efforts to investigate alleged healthcare fraud is at an all-time high. In March, the White House **established** an anti-fraud task force led by Vice President JD Vance.



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The [U.S. Department of Justice](#) is **restructuring** to create a division focused exclusively on fraud against the government. Even the [Centers for Medicare & Medicaid Services](#) is broadcasting its efforts to crush fraud.[1]

Beneath these big-font headlines, a more specific trend is emerging: behavioral healthcare providers receiving a disproportionate share of heightened scrutiny. Recent law enforcement scrutiny of the industry has resulted in numerous settlements, indicating that more enforcement activity is likely on its way. Behavioral health companies would be well advised to recognize this shift and take proactive steps to mitigate risk.

Recent Examples of Surging Behavioral Health Enforcement

Over the past year, there has been a notable volume of settlements involving behavioral health providers. The raw volume of settlements — each following years of investigation — is striking, as is the wide variety of allegations made against many parts of the behavioral healthcare industry.

For instance, Seabrook, a New Jersey rehabilitation facility, **paid** \$19.75 million last May to resolve allegations that it billed for short-term residential treatment and partial hospitalization services for which it was not properly licensed, and that staff were not properly credentialed.

Other million-dollar-plus settlements followed: In August, Comprehensive Psychiatric Services paid \$2.75 million; and in December, [Recovery Centers of America](#) paid \$2 million and Mindpath Care Centers of North Carolina paid \$1.9 million.

The specific allegations vary, but the broader trend is consistent: Behavioral health is not a niche area for enforcement. Regulators are scrutinizing the industry from multiple angles, and recent settlements suggest that providers can expect continued attention, especially

where government program billing, documentation, telehealth, patient referrals or operational controls are involved.

Trends Emerging From These Cases

Enforcement spans providers of all sizes.

First, enforcement spans the full spectrum of providers, from solo practitioners to large organizations. The government's willingness to invest its resources in cases against modest-sized providers — providers that may think they are too small for DOJ scrutiny — underscores the government's heightened interest in this part of the industry.

Billing and coding remain the primary entry point.

Second, many of the settlements involve alleged coding and billing deficiencies. It is typical for government scrutiny of a subindustry to start with billing investigations because there is a direct connection between alleged miscoding and false claims.

Billing investigations also have a high likelihood of some financial recovery for the government — even if billing mistakes were in good faith, they still result in overpayment recoveries.

Also, a historical lack of billing investigations often correlates with some providers taking more aggressive billing. As such, providers should consider investing in processes and controls to ensure that claims are accurate, properly documented and compliant with program requirements — especially for government program patients.

EKRA is not yet a primary enforcement driver, but it remains a signal.

Notably, the settlements largely do not reflect alleged violations of the Eliminating Kickbacks in Recovery Act.

Congress passed EKRA in 2018 to prohibit kickbacks in the substance abuse treatment industry. This law carries criminal penalties, and it is not limited to federal benefit programs.

At the time it was enacted, there was a lot of speculation about why Congress thought that it was necessary to pass anti-fraud legislation specific to the substance abuse treatment

industry. EKRA can be seen as a signal that the government is concerned about financial relationships in the behavioral health industry.

Why Behavioral Health Enforcement Will Continue

The behavioral health industry has several characteristics that indicate that it will be the target of government enforcement activity for a while longer.

First, there has been significant growth in behavioral health, including the expansion of Medicare and Medicaid coverage. With growth comes growing pains, followed by suspicion and often enforcement. The simple fact that more dollars — including federal dollars — are being spent on behavioral health inherently means an increase in scrutiny.

Second, behavioral health services frequently overlap with telehealth, another rapidly evolving area that has drawn regulatory attention. Many in the government don't know what to make of telehealth, and the ambiguities scare them.

This uncertainty and concern are reflected in the congressional and administrative piecemeal approach to telehealth issues. In other words, the government seems to think that both telehealth and behavioral health are areas ripe for potential fraud, and therefore we should expect more enforcement, especially where those services overlap.

Third, behavioral health providers often interact with federal healthcare programs in atypical ways. Some providers do not participate in Medicare or Medicaid at all, while others rely heavily on Medicaid or serve beneficiaries of programs such as Tricare or the Veterans Health Administration.

This uneven and unusual interface presents issues for both providers and the government. For example, providers that historically only accepted cash or commercial insurance may not fully appreciate the burdens that come with accepting even a small number of government program patients.

A Clear Message for Providers: Be Smart, Act Now

Prudent providers will recognize this enforcement trend and take proactive steps to reduce the risk of being caught in the approaching enforcement dragnet.

Start with a targeted risk assessment.

A behavioral health provider's initial step should be to conduct a risk assessment that outlines that provider's unique regulatory and compliance vulnerabilities. This assessment can include a quick index of typical risk areas: billing and coding, licensure and accreditation, telehealth, financial relationships with referral sources, marketing activities, data security, etc.

An initial assessment can raise a number of questions that could indicate a need for a deeper dive, such as: When was our last coding audit? Are our data security processes up to date? Did the last state licensure survey find material deficiencies with our licensure standards?

Implement or strengthen a compliance program.

A compliance program formalizes a company's efforts to comply with its legal obligations. Many behavioral health companies have compliance programs, and they are commonplace in the larger healthcare industry.

Compliance programs can be quite effective in reducing regulatory and legal risk by having existing administrative structures that proactively monitor compliance and preemptively remediate mistakes, inadvertent noncompliance and unfounded allegations. As companies grow, compliance programs allow senior management to gain insight into the risks and risk reduction inherent in operating in a highly regulated industry.

Establish controls around financial relationships.

Finally, smart behavioral health providers will implement controls related to financial relationships with referral sources and patients. Payments to referral sources is an area of high enforcement across the larger healthcare industry, and behavioral health providers are not exempt from such allegations.

While all payments to or from a referral source, including a hospital, physician or other treatment program, could be subject to scrutiny as a potential kickback, a good contracting process can mitigate that risk.

Because behavioral health patients often self-refer, providers need controls related to the large number of potential financial relationships with patients, including sales and marketing, new patient onboarding, travel costs, support while in treatment, supportive

housing, and copay and deductible collections.

Many well-meaning ideas can pose significant legal and regulatory risk if not properly implemented. Thoughtful policies and controls in these areas are essential.

Conclusion

Federal enforcement authorities have clearly turned their attention to the behavioral health industry. As investigations and settlements continue, providers should expect sustained scrutiny.

While this trend presents challenges, it also offers an opportunity: Organizations that take proactive compliance measures now will be better positioned to navigate an increasingly active enforcement landscape.

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[1] <https://www.cms.gov/fraud>.